Chief, Health Care Integration: Roles and Responsibilities

As a member of the Primary Care Team, the Chief of Health Care Integration integrates population-based health care by building healthy communities and ensuring a healthy, fit and ready force. The Chief participates in disease and case management, (condition management), for the managed population, and performs Population Needs Assessments by collecting, analyzing, and describing individual and group characteristics, (age, gender etc.), and health needs and practices (currency for preventive services, health-care utilization etc.). He or she uses the Put Prevention Into Practice (PPIP) program to ensure enrollees receive timely and preventative interventions. The Chief of Health Care Integration interprets results of Health Risk Assessment (HRA) surveys, prioritizes identified risk factors, and triages/refers patients to the assigned primary care manager, Health and Wellness Center (HAWC), or other preventive programs as appropriate. This team member oversees and participates in Military Treatment Facility (MTF) education programs, uses and develops protocols in conjunction with existing clinical guidelines and develops and monitors tools and metrics to evaluate and continuously improve the effectiveness of programs and the health of the population. The Chief communicates and collaborates with the Primary Care Manager (PCM) and members of the health care team and also serves as a patient advocate by assuming the role of liaison between the patient, PCM, ancillary services, HAWC, and appropriate civilian organizations. The Chief of Health Care Integration establishes links with inpatient and contracted case managers/discharge planners to coordinate services through the continuum of care for patients who have barriers to timely discharge. Finally, the Chief provides essential partnering with the civilian community, such as home health care, to prevent hospitalization, and educates/counsels patients and makes appropriate recommendations/referrals, and monitors as needed.

The specific responsibilities of the Chief of Health Care Integration include:

1. General Duties

   - Assess patients' needs, and then take appropriate action to include; referral of patients to Primary Care Manager (PCM), Health and Wellness Center (HAWC), or services as required; provide patient education.
   - Access information systems to identify members at risk for disease, implement disease management plan, quantify program effectiveness, and document intervention.
   - Review and annually update operating instructions and practices to ensure compliance with accreditation, quality assurance, legal, and other regulatory requirements.

2. Provide Leadership

   - Develop and monitor program goals and objectives consistent with clinic's Medical Mission Support Plan.
   - Participate in program planning, development, and evaluation, in collaboration with PCM, all departments, HAWC, and community services.
   - Assist in the collaborative development and maintenance of clinical guidelines that describe and predict the plan of treatment for a specific patient population.
   - Develop interdisciplinary management style through effective communication and collaboration with appropriate departments.
   - Collaborate with all clinic and hospital personnel on matters relating to case management, discharge planning, and prevention and utilization management.

3. Stay Current on Changes in Medical and Administrative Arenas

   - Participate in professional development activities and maintain professional affiliations. Attend conferences and workshops.
   - Maintain current knowledge of the process of disease management, current trends in prevention, and epidemiological-based researching.

- Assist with development of research protocols and actively participate in facility research processes.

4. Organizational Responsibilities

   - Develop systematic method for executing plans and programs to educate members about prevention/disease management.
   - Promote effective health management by identifying members with chronic/high-risk, high volume illnesses/needs, and implement appropriate programmatic responses.
   - Coordinate local PPIP activities, arrange education and skills training sessions, order materials, promote/market PPIP for the population enrolled to the clinic team.
   - Continually re-assess and refine PPIP program; evaluate and implement new or changing preventative recommendations; and develop local preventative protocols for the clinic team.
   - Identify barriers to PPIP implementation, and coordinate with primary care team to resolve problems and improve processes.
   - Set priorities for prevention activities and integrate efforts with health promotion programs.
   - Track financial and clinical outcome data for the targeted at-risk population enrolled to determine the effectiveness of the disease management treatment plans.
   - Develop reports to provide current and meaningful data from which assessments can be made to determine effectiveness of prevention efforts.
   - Develop protocols for the timely identification and referral of patients who require follow-up for significant problems or illnesses, to include evaluation of laboratory studies.
   - Evaluate community health services to select appropriate referral agencies; monitors patient satisfaction.

5. Responsibilities Requiring the Exercise of Judgment and Making Decisions

   - Educate and counsel patients about their potential risk for disease or injuries, make appropriate recommendations/referrals, and monitor the patients' participation in wellness programs.
   - Access information systems to analyze, track and quantify program effectiveness, and to manage the dissemination of information critical to the success of the population health management model.
   - Triage questions regarding medical necessity, appropriateness of care, and quality concerns to PCM/Medical Staff.
   - Intervene with appropriate individuals/departments regarding delays in service that may have an impact on quality of patient care.

6. Communication

   - Communicate and collaborate with the PCM and appropriate members of the health care team to ensure that needs of assigned patients are met without duplication of efforts.
   - Serve as a patient advocate by assuming the role of a liaison between the patient, PCM, ancillary services, HAWC, and appropriate civilian organizations.
   - Serve as a liaison with social services and the civilian community to coordinate actions, which prevent hospitalization; such as home health care.
   - Establish liaisons with inpatient case managers/discharge planners to coordinate services through the continuum of care for patients who, due to age, illness, support systems or environmental issues, have barriers to timely discharge.

The qualifications required to serve as Chief of Health Care Integration include:

- <u>Knowledge</u>:

- An understanding of the multi-disciplinary roles of all caregivers, and an ability to function in a “team approach” to health care
- An ability to identify members at risk for disease, implement disease management plans, and quantify program effectiveness utilizing available information systems
- Possession of knowledge of current operational instruction and updates to ensure compliance with accreditation, quality assurance, local state laws, legal and other regulatory requirements.
- Knowledge of MTF’s Mission Support Plan, program planning and collaborative efforts. Knowledge of clinical guidelines that predict the plan of treatment for a specific patient population.
- Maintenance of current knowledge of the process of disease management, current trends in prevention, and epidemiological based resources.
- Knowledge of research protocols and participation in research process.

Education:

- Baccalaureate of Science degree from accredited educational institution is required.
- An advanced degree in a health care discipline is highly desirable.
- National certification is recommended.

Experience:

- Broad clinical background is required with at least five years in progressively responsible positions in acute care and outpatient settings.
- Experience in quality assessment/improvement, case management, and discharge planning and/utilization management experience preferred.
- Familiarity with essential information systems such as the Composite Health Care System (CHCS) and Ambulatory Data System (ADS) is necessary.